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A 000	Initial Comment Facility Reported Incident Investigation to incident of 03-06-26/IL#200650. 295.4010 a) d) e) 295.4060 h) 3) A) B)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).	A4010		

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A4010	Continued From page 1 Based on interview and record review, the establishment failed to ensure a Service Plan was revised after a significant change in condition for one of three residents (R2) reviewed for Service Plans in the sample of three. This failure caused harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: R2's Progress Note (dated 12/29/25) documents the following: "Resident admitted to (local hospice provider) with diagnosis of cerebrovascular disease. New orders to discontinue aspirin, vitamin D3, donepezil and rosuvastatin. New orders to start Hydrocodone 5-325 milligrams every 6 hours PRN (as needed) for pain; lorazepam 0.5 milligrams every 5 hours PRN for anxiety/restlessness; and Senna 8.6 (milligrams) twice daily PRN for constipation." R2's current Service Plan (dated 09/18/25) documents R2 does not require any assistance with transfers and mobility. On 03/25/26 at 11:50 AM, E4 indicated that she regularly cares for R2 and stated the following: "(R2) has severe cognitive impairment. She is under the care of hospice, and she requires assistance with all of her ADLs (activities of daily living). She requires one staff assistance for transfers and mobility, and if she is having a bad day, sometimes two staff will assist her. She will attempt to self-transfer, but it is becoming more rare due to her impaired cognition and she isn't very motivated anymore." On 03/25/26 at 01:25 PM, E5 (Certified Nursing Assistant) stated that R2 is typically a one assist	A4010		

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A4010	Continued From page 2 with her ADLs, but she has required two assist at times on a "bad day." E5 stated, "She is on hospice. She will occasionally attempt to stand unassisted, but not as much as she used to." R2's Adverse Event Investigation (dated 01/21/26) documents R2 had an unwitnessed fall at the establishment, at which time she stood without staff assistance and began walking towards the kitchenette before falling to the floor. On 03/25/26 at 02:20 PM, E3 (Director of Lifestyle Enrichment) stated that R2's Service Plan is currently inaccurate. E3 stated R2 requires staff assistance with all of her ADLs (activities of daily living), and her Service Plan should have been revised after R2 was admitted under the care of hospice services on 12/29/25.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who:	A4060		

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A4060	Continued From page 3 A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; Based on interview and record review, the establishment failed to implement their 'Safe Lifting and Movement' policy and ensure fall prevention interventions were implemented for three of three residents (R1-R3) reviewed for falls in the sample of three. This failure caused severe harm to a resident or creates a substantial probability of severe harm to a resident or residents. Findings include: The establishment's 'Safe Lifting and Movement of Residents' policy (revised 10/14/19) documents the following: "In order to protect the safety and well-being of staff and residents, and to promote quality care, this community uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation: Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents." This policy also documents, "Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, slide boards) and mechanical lifting devices." The establishment's 'Management of Fall Risk' policy (revised 01/30/24) documents, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."	A4060		

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A4060	Continued From page 4 1. On 03/24/26 at 11:50 AM, E1 (Administrator) stated the following: R1 had a fall on 02/07/26 while residing in the community's skilled rehabilitation unit (skilled stay from 01/12/26 - 02/20/26); R1 was sent to the hospital after her fall on 02/07/26, and returned to the community's skilled rehabilitation unit on 02/09/26; R1 was then transferred and admitted to the community's Memory Care Unit on 02/20/26 from the community's skilled rehabilitation unit; R1 fell at the establishment on 03/06/26, was sent out to a local hospital, and returned to the establishment later that same day with multiple injuries; R1 was admitted to hospice services upon her return from the hospital, remained under the care of hospice services while residing in Memory Care, and passed away at the establishment on 03/18/26. R1's medical record documents R1's diagnoses to include: Dementia, Adult Failure to Thrive, and Disorientation. R1's most current Service Plan documents R1 requires 'minimal assist' with transfers and mobility. On 03/25/26 at 11:05 AM, E3 (Director of Lifestyle Enrichment) stated minimal assist as noted on R1's Service Plan indicates assistance of one staff member. E3 stated R1 was an assist of one with the majority of her ADLs (activities of daily living), and required assist of one with transfers and mobility. E3 then stated, "(R1) was very social and friendly. She was very forgetful, especially her short-term memory. At the end of a conversation, she would not be able to recall the beginning of it. She wore a call pendant. She spent most of her time out in the common area, so she did not have to utilize her call pendant often because she would just get a staff	A4060		

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A4060	Continued From page 5 member's attention for her needs." R1's Adverse Event Investigation (dated 03/06/26) documents the following: "At 07:30 AM resident's nurse was notified that resident alerted CNA (Certified Nursing Assistant) via pendant and is on the floor. Upon entering the room, the resident was found on the floor, in a pool of blood, with blood smeared all over her face. It was quickly noted that resident had a large hematoma over her left eye along with an approximate 1.5 centimeter laceration over same eye. Resident was quickly assessed and moved into a wheelchair. Vital Signs: Blood Pressure 153/83, 68 Pulse, Oxygen Saturation 98% on RA (room air), 22 Respiratory Rate. Resident unable to provide a number on pain scale, she just stated, 'her lip is swollen and her head hurts.' Temperature untaken due to blood covering the forehead. Resident was cleaned up, direct pressure applied and TAO (triple antibiotic ointment) were used to impede the bleeding. Emergency services were phoned and (local medics) took resident to (local hospital) at 07:59 AM. Family, supervisor and PCP (primary care physician) all notified." R1's Progress Note (dated 03/06/26 at 02:49 PM) documents the following: "Resident returned via EMS (Emergency Medical Services) stretcher. Family present. Transferred to bed. Nursing assessment completed. Laceration 6 cm (centimeters) to left orbital area, three sutures in place. Bruising to left orbital area and left cheek. Lip bruising and swelling. Resident happy to be back in apartment. Family stated resident has a long history of falling hitting her head related to locking her legs and lack of ability to brace her falls with the upper body. Education regarding plan of care updates: Resident will not utilize	A4060		

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walker for transfers. Wheelchair will be encouraged and utilized. Will order hospital bed for unsafe attempts to transfer self. Staff educated. Family is in agreement. (Local hospice provider) to consult. Resident resting in bed with family present."

R1's Progress Note (dated 03/18/26) documents, "Writer called to resident's room, daughter at bedside. Resident had no signs of life. Time of death verified by writer and (E6, Licensed Practical Nurse) at 08:20 PM ..."

On 03/25/26 at 11:40 AM, E4, CNA (Certified Nursing Assistant) stated she has worked at the establishment for approximately three years, and she regularly cared for R1 while R1 resided at the establishment. E4 stated, "(R1) has been at the community for a while. I cared for her often in Memory Care. She required assistance of one with toileting, dressing, and showers, transfers and mobility. She was a fall risk, so a staff member needed to stand next to her for prompting. (R1) was strong, but unbalanced. She really needed guidance getting from one spot to another. She would often try to self-transfer due to her impaired cognition, which caused her to forget her limitations. (R1) spent the majority of the time in her wheelchair. She had a walker for short distances, but if she left her room she would utilize her wheelchair. She spent most of her time in the common area because she was so social. If she needed something, she would flag a staff member down. She did wear a pendant and would occasionally push it, but the majority of the time she would just get a staff member's attention and communicate her needs." E4 indicated she was the staff member that initially responded to R1's fall on 03/06/26 and stated, "I discovered (R3) after she had fallen shortly after my shift

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began. The door to her room was closed and locked, and she did not lock her door often. I had been told she is afraid of males, and a male CNA had worked the night shift before leading me to believe that is why her door was locked. After she fell, she had pushed her pendant, and I had to go grab the key since I found her door locked. When I opened the door, she was on the ground near her door. It appeared that she had stood and walked with her walker toward her door, as her walker was nearby and had been knocked over. There was quite a bit of blood, and she had a big knot on her head. I called for help right away and (R1) was sent to the hospital."

On 03/25/26 at 01:15 PM, E5, CNA (Certified Nursing Assistant) stated she has worked at the establishment for eight years, and frequently cared for R1 while R1 resided at the establishment. E5 stated, "(R1) was an assist of one, and required prompting. When she first admitted to Memory Care, she seemed to use her walker more, or sometimes she would propel in her wheelchair. (R1's) short-term memory was severely impaired, so she could not retain anything for more than a few moments. She had a pendant to call for help and she could use it, but she did not use it often. She spent most of her time out in the common area and would just flag a staff member down if she needed something. I was working the day she fell (03/06/26), but I was assigned to the other side of the building, so I was not one that responded after she had fallen."

R1's (local hospital) medical record (dated 03/06/26) documents R1 sustained the following injuries from her fall on 03/06/26: Multifocal areas of subarachnoid hemorrhage within the bilateral frontal and temporal lobes; Small subdural hematomas along the anterior falx and

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inferolateral right frontal lobe; Fractures of the left orbital floor, inferolateral left orbital wall, posterior wall of the left maxillary sinus and right lateral pterygoid plate; Prominent left-sided preseptal periorbital soft tissue swelling and hemorrhage." This same medical record also documents, "Discharge Plan: Clinical Impression: Acute subdural hematoma, Subarachnoid hemorrhage, Facial laceration, Extensive facial fractures. Additional Instructions: Patient was made comfort care by family, patient will be started on hospice, (local hospice provider). Patient does have a facial laceration (sutures need to be removed in 5-7 days), multiple facial fractures and multiple subdural hematomas and subarachnoid hemorrhages."

On 03/25/26 at 02:15 PM, E3 (Director of Lifestyle Enrichment) stated R1's 03/06/26 fall at the establishment was unwitnessed, and therefore, staff was not providing R1 with the assistance that she required as noted in her Service Plan.

2. R2's medical record documents R2's current diagnoses to include: Alzheimer's Disease, Dementia, Major Depressive Disorder, and Insomnia.

On 03/25/26 at 11:50 AM, E4 (Certified Nursing Assistant) indicated that she regularly cares for R2 and stated the following: "(R2) has severe cognitive impairment. She is under the care of hospice, and she requires assistance with all of her ADLs (activities of daily living). She requires one staff assistance for transfers and mobility, and if she is having a bad day, sometimes two staff will assist her. She will attempt to self-transfer, but it is becoming more rare due to her impaired cognition and she isn't very

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motivated anymore."

On 03/25/26 at 01:25 PM, E5 (Certified Nursing Assistant) stated that R2 is typically a one assist with her ADLs, but she has required two assist at times on a "bad day." E5 stated, "She is on hospice. She will occasionally attempt to stand unassisted, but not as much as she used to."

R2's Adverse Event Investigation (dated 03/14/26) documents the following: "This nurse was notified by CNA (Certified Nursing Assistant) that the resident had a witnessed fall in her apartment bathroom. Upon entering the room, the resident was found sitting on the floor on her buttock against the wall. CNA and resident denied hitting her head. CNA reported to this nurse that the resident lost her balance while CNA was assisting the resident to the wheelchair. Nursing assessment completed. No visible injuries noted. Range of Motion/Vital Signs within normal limits. Resident denied pain and discomfort at this time. The resident was assisted back to the wheelchair with staff assistance of nurse and CNA. MD (Medical Doctor), POA (Power of Attorney), Supervisor made aware."

On 03/25/26 at 02:20 PM, E3 (Director of Lifestyle Enrichment) stated, "The CNA did not use a gait belt when (R2) fell while being transferred on 03/06/26. A gait belt should have been used when (R2) was transferred. We administered education after (R2's) fall."

R2's Adverse Event Investigation (dated 01/21/26) documents, "At 11:20 AM, Nurse was notified by CNA of resident being on the floor. Resident was transferring self, walking towards the kitchenette when she fell. Upon assessing resident everything is unremarkable. Vitals were

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taken, (local hospice provider) & family notified. At this time, we are monitoring resident for any adverse effects."

On 03/25/26 at 02:25 PM, E3 (Director of Lifestyle Enrichment) stated R2 was admitted to hospice services on 12/29/25, and R1 requires assistance of one staff member for transfers and mobility. E3 verified that no staff member was present to provide assistance when R2 fell on 01/21/26.

3. R3's medical record documents R3's current diagnoses to include: Dementia, Interstitial Pulmonary Disease, Major Depressive Disorder, Atrial Fibrillation, Polyosteoarthritis, Tremor, and History of Falling.

R3's current Service Plan documents R3 requires Minimal Assist (assist of one) with transfers and mobility.

R3's Adverse Event Investigation (dated 02/28/26) documents the following: "CNA (Certified Nursing Assistant) notified this nurse of an unwitnessed fall in resident's apartment. Upon entering the room resident observed lying on the floor next to her bed with pillow underneath her head. Resident noted to be wearing regular socks and no shoes and no pants on. Resident stated she was attempting to get a pair of pants when she fell. Resident denied hitting her head. Denied pain or discomfort at time of assessment. No visible injuries or redness noted. ROM (range of motion) within normal limits. Vitals signs obtained and within normal limits. Resident assisted up to chair with two staff using gait belt without difficulty. Resident assisted to bathroom. Education provided on fall precautions and importance of using call light for assistance prior

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A4060	Continued From page 11 to ambulation." On 03/25/26 at 12:00 PM, E4 (Certified Nursing Assistant) stated the following regarding R3: "(R3) is very forgetful. She wouldn't know a call light if you asked her to use one. She is stiff in her arms and legs, and I think her disease has caused this and it limits her mobility. She requires one staff assist for all of her ADLs (activities of daily living). She uses her wheelchair more than her walker and seems to require more care nowadays. I have noticed she needs quite a bit of assistance with feeding. She seems to give up in the middle of a task because it is too much for her current level of cognition." On 03/25/26 at 01:30 PM, E5 (Certified Nursing Assistant) stated, "(R3) requires one staff assist. You have to keep a closer eye on her. She is impulsive and has no recollection of her limitations. You really have to watch her when she is in her room because she will attempt to get up without calling for help. We always keep the door of her room open when she is in there." On 03/25/26 at 02:25 PM, E3 (Director of Lifestyle Enrichment) stated R3's 02/28/26 fall at the establishment was unwitnessed, and therefore, staff was not providing R3 with the required assistance noted in her Service Plan.	A4060		